

# **Alternate Care Operating Budget**

Year: 2016

Fiscal Data Collection Form

## **Annual Expenses**

<b>Name of Organization</b>	
<b>Program Name</b>	
<b>Number of Licensed Beds</b>	

Direct Care Staff	Hours/ Day	Total Hours Annually	Average Hourly Wage	Total Wages
1st Shift - Weekdays		0	\$ -	\$ -
2nd Shift - Weekdays		0	\$ -	\$ -
3rd Shift AWAKE Weekdays		0	\$ -	\$ -
3rd Shift ASLEEP Weekdays		0	\$ -	\$ -
1st Shift - Weekends		0	\$ -	\$ -
2nd Shift - Weekends		0	\$ -	\$ -
3rd Shift AWAKE Weekends		0	\$ -	\$ -
3rd Shift ASLEEP Weekends		0	\$ -	\$ -
<b>TOTALS</b>		0	\$ -	\$ -
Paid Off Time (Vacation, sick, holiday...)		300	\$ -	\$ -
<b>Total Direct Care Staff</b>		300	\$ -	\$ -

Other Staff Costs (Excluding Direct Care Staff)	# of FTE	Hours/Year	Hourly Rate	Annual Cost
Support Staff (clerical, drivers, maintenance...)	0	0	\$ -	\$ -
Program Management Staff	0	0	\$ -	\$ -
Nursing	0	0	\$ -	\$ -
Supervisory Staff	0	0	\$ -	\$ -
Executive/Administrative Staff	0	0	\$ -	\$ -
<b>Totals</b>	0	0	\$ -	\$ -

**Profit** \$ -

Owner's Salary	Annual Cost
\$ -	\$ -
<b>Benefits And Taxes</b>	<b>Annual Cost</b>
Workers Compensation	\$ -
Unemployment	\$ -
FICA	\$ -
Health Insurance	\$ -
Retirement	\$ -
Long Term Disability	\$ -
Short Term Disability	\$ -
Life Insurance	\$ -
Other-	\$ -
<b>Total Benefits</b>	\$ -

Other Staff Expenses	Annual Cost
Staff Training	\$ -
Staff Mileage	\$ -
Staff Recruitment, drug screens, background checks	\$ -
Other	\$ -
<b>Total Other Staff Expenses</b>	\$ -

Transportation	Annual Expense
Vehicle Depreciation (or lease)	\$ -
Interest	\$ -
Gas, oil	\$ -
Repairs and Maintenance	\$ -
Insurance	\$ -
License/Permits	\$ -
Public Transportation (bus & cab tickets)	\$ -
Other	\$ -
<b>Total Transportation</b>	\$ -

Other Operating Costs	Annual
Office Occupancy Costs	\$ -
Insurance (other than property/casualty)	\$ -
Office supplies and furnishings	\$ -
Office Telephone	\$ -
Postage	\$ -
Operating Fees/permits/licenses	\$ -
Professional Fees	\$ -
Audit Fees	\$ -
Legal Fees	\$ -
Other	\$ -
Indirect Overhead Costs (please identify costs)	\$ -
Other	\$ -
<b>Total Other Operating Costs</b>	\$ -

Room and Board	Annual Expense
Property Depreciation	\$ -
Property Interest	\$ -
Rent	\$ -
Property/Casualty Insurance	\$ -
Property Taxes	\$ -
Building/Grounds Maintenance	\$ -
Maintenance Salaries	\$ -
Resident Food	\$ -
Household Supplies	\$ -
Household Equipment	\$ -
Resident Furnishings	\$ -
Utilities	\$ -
Resident Phone	\$ -
Cable TV	\$ -
Other Housing Costs	\$ -
Total Room & Board/Facility	\$ -
Total Room & Board/Person	#DIV/0!
Daily Room & Board/Person	#DIV/0!

Expense Summary	
Total Support and Services	\$ -
DAILY RATE - Support	#DIV/0!
Total Room and Board	\$ -
DAILY RATE - R & B	#DIV/0!
Total Program Cost	\$ -
DAILY RATE - Total Program	#DIV/0!
Indirect Overhead %	#DIV/0!

Income Summary	
Care Support & Services	\$ -
Other Contracts	\$ -
SSI/Room & Board Payments	\$ -
MAPC*	\$ -
Hud Credit	\$ -
Other	\$ -
<b>Total</b>	\$ -

\*Medical Assistance Personal Care

Name of Person Completing the Form	
Phone Number	
Date Completed	

Number of Family Living in Facility	

Please enter data in unprotected cells. If entering a dollar amount in an "other" category, please change "other" to a descriptive name for that entry.

If living in the facility please see "Space Costs" section of the Allowable Cost Policy Manual.